DIAGNOSTIC REPORT

Patient Ref. No. 775000001933147

SRL Diagnostics

CLIENT CODE : C000138354

CLIENT'S NAME AND ADDRESS :
ACROFEMI HEALTHCARE LTD (MEDIWHEEL)
F-703, LADO SARAI, MEHRAULI
SOUTH WEST DELHI
NEW DELHI 110030
DELHI INDIA
8800465156

SRL Ltd
Shop CG 017, PALM SPRINGS PLAZA
GURUGRAM, 122001
HARYANA, INDIA
Tel : 9111591115

PATIENT NAME : GEETANJALI SETHI PATIENT ID : **GEETF210670282**

ACCESSION NO : **0282VK002109** AGE : 52 Years SEX : Female ABHA NO :

DRAWN : RECEIVED : 28/11/2022 08:41:16 REPORTED : 29/11/2022 12:31:04

REFERRING DOCTOR : SELF CLIENT PATIENT ID :

Test Report Status **Final**	Results		Biological Reference Interval	Units
MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE				
BLOOD COUNTS,EDTA WHOLE BLOOD				
HEMOGLOBIN (HB)	**11.6**	**Low**	12.0 - 15.0	g/dL
METHOD : SPECTROPHOTOMETRY				
RED BLOOD CELL (RBC) COUNT	4.67		3.8 - 4.8	mil/µL
METHOD : IMPEDANCE				
WHITE BLOOD CELL (WBC) COUNT	9.48		4.0 - 10.0	thou/µL
METHOD : IMPEDANCE				
PLATELET COUNT	381		150 - 410	thou/µL
METHOD : IMPEDANCE				
RBC AND PLATELET INDICES				
HEMATOCRIT (PCV)	**35.0**	**Low**	36 - 46	%
METHOD : CALCULATED				
MEAN CORPUSCULAR VOLUME (MCV)	**74.9**	**Low**	83 - 101	fL
METHOD : DERIVED FROM IMPEDANCE MEASURE				
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	**24.8**	**Low**	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER				
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	33.1		31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER				
RED CELL DISTRIBUTION WIDTH (RDW)	**17.1**	**High**	11.6 - 14.0	%
METHOD : DERIVED FROM IMPEDANCE MEASURE				
MENTZER INDEX	16.0			
MEAN PLATELET VOLUME (MPV)	8.1		6.8 - 10.9	fL
METHOD : DERIVED FROM IMPEDANCE MEASURE				
WBC DIFFERENTIAL COUNT				
NEUTROPHILS	60		40 - 80	%
METHOD : DHSS FLOWCYTOMETRY				
LYMPHOCYTES	32		20 - 40	%
METHOD : DHSS FLOWCYTOMETRY				
MONOCYTES	6		2 - 10	%
METHOD : DHSS FLOWCYTOMETRY				
EOSINOPHILS	2		1 - 6	%
METHOD : DHSS FLOWCYTOMETRY				
BASOPHILS	0		0 - 2	%
METHOD : IMPEDANCE				

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ABSOLUTE NEUTROPHIL COUNT	5.66		2.0 - 7.0	thou/µL
METHOD : DHSS FLOWCYTOMETRY, CALCULATED				
ABSOLUTE LYMPHOCYTE COUNT	**3.04**	**High**	1 - 3	thou/µL
METHOD : DHSS FLOWCYTOMETRY, CALCULATED				
ABSOLUTE MONOCYTE COUNT	0.55		0.20 - 1.00	thou/µL
METHOD : DHSS FLOWCYTOMETRY, CALCULATED				
ABSOLUTE EOSINOPHIL COUNT	0.22		0.02 - 0.50	thou/µL
METHOD : DHSS FLOWCYTOMETRY, CALCULATED				
ABSOLUTE BASOPHIL COUNT	**0.01**	**Low**	0.02 - 0.10	thou/µL
METHOD : DHSS FLOWCYTOMETRY, CALCULATED				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	1.9			
METHOD : CALCULATED				
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD				
E.S.R	**29**	**High**	0 - 20	mm at 1 hr
METHOD : AUTOMATED (PHOTOMETRICAL CAPILLARY STOPPED FLOW KINETIC ANALYSIS)				
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD				
HBA1C	**6.9**	**High**	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 ADA Target: 7.0 Action suggested: > 8.0	%
METHOD : CAPILLARY ELECTROPHORESIS				
ESTIMATED AVERAGE GLUCOSE(EAG)	**151.3**	**High**	< 116	mg/dL
METHOD : CALCULATED PARAMETER				

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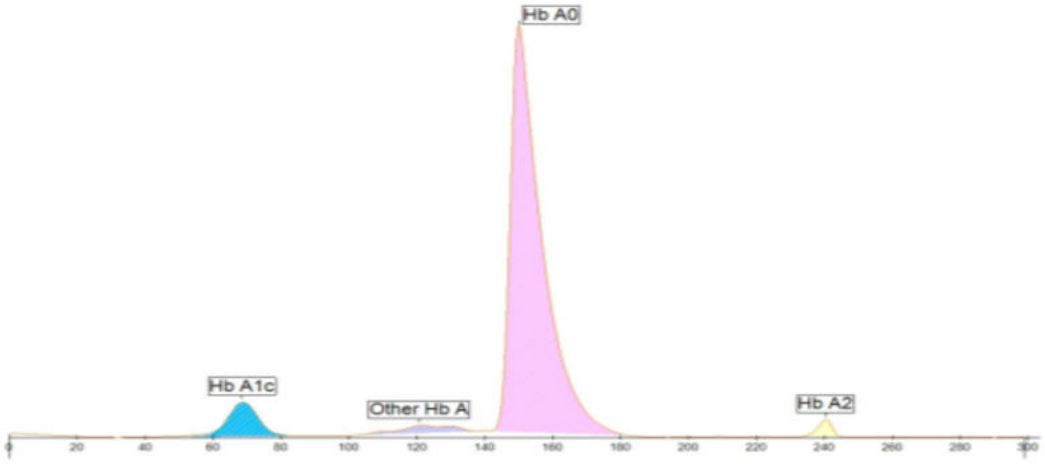
PLOT NO.31,ELECTRONIC CITY,SECTOR 18, GURUGRAM

ID : 28212503783
Name :

Sample Date: 11/29/2022
Sample num.: 3



A1c Haemoglobin Electrophoresis

Fractions	%	mmol/mol	Cal. %
Hb A1c	-	**51**	6.9
Other Hb A	2.6		
Hb A0	88.9		
Hb A2	1.8		

HbA1c % cal :**6.9 %** >

Comments :

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GLUCOSE FASTING,FLUORIDE PLASMA				
FBS (FASTING BLOOD SUGAR)	**106**	**High**	Normal 75 - 99 Pre-diabetics: 100 – 125 Diabetic: > or = 126	mg/dL
METHOD : SPECTROPHOTOMETRY HEXOKINASE				
GLUCOSE, POST-PRANDIAL, PLASMA				
PPBS(POST PRANDIAL BLOOD SUGAR)	**169**	**High**	70 - 139	mg/dL
METHOD : SPECTROPHOTOMETRY, HEXOKINASE				
LIPID PROFILE, SERUM				
CHOLESTEROL, TOTAL	118		Desirable cholesterol level < 200 Borderline high cholesterol 200 - 239 High cholesterol > / = 240	mg/dL
METHOD : ENZYMATIC COLORIMETRIC ASSAY				
TRIGLYCERIDES	134		Normal: < 150 Borderline high: 150 - 199 High: 200 - 499 Very High: >/= 500	mg/dL
METHOD : ENZYMATIC COLORIMETRIC ASSAY				
HDL CHOLESTEROL	**36**	**Low**	Low HDL Cholesterol <40 High HDL Cholesterol >/= 60	mg/dL
METHOD : HOMOGENEOUS ENZYMATIC COLORIMETRIC ASSAY				
CHOLESTEROL LDL	56		Adult levels: Optimal < 100 Near optimal/above optimal: 100-129 Borderline high : 130-159 High : 160-189 Very high : = 190	mg/dL
METHOD : HOMOGENEOUS ENZYMATIC COLORIMETRIC ASSAY				
NON HDL CHOLESTEROL	82		Desirable : < 130 Above Desirable : 130 -159 Borderline High : 160 - 189 High : 190 - 219 Very high : > / = 220	mg/dL
METHOD : CALCULATED PARAMETER				
CHOL/HDL RATIO	**3.0**	**Low**	Low Risk : 3.3 - 4.4 Average Risk : 4.5 - 7.0 Moderate Risk : 7.1 - 11.0 High Risk : > 11.0	

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METHOD : CALCULATED PARAMETER				
LDL/HDL RATIO	1.6		0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
METHOD : CALCULATED PARAMETER				
VERY LOW DENSITY LIPOPROTEIN	26.8		< OR = 30.0	mg/dL
METHOD : CALCULATED PARAMETER				
LIVER FUNCTION PROFILE, SERUM				
BILIRUBIN, TOTAL	0.3		Upto 1.2	mg/dL
METHOD : COLORIMETRIC DIAZO METHOD				
BILIRUBIN, DIRECT	0.2		< 0.30	mg/dL
METHOD : COLORIMETRIC DIAZO METHOD				
BILIRUBIN, INDIRECT	0.10		0.1 - 1.0	mg/dL
METHOD : CALCULATED PARAMETER				
TOTAL PROTEIN	7.9		6.0 - 8.0	g/dL
METHOD : SPECTROPHOTOMETRY, BIURET				
ALBUMIN	4.5		3.97 - 4.94	g/dL
METHOD : SPECTROPHOTOMETRY, BROMOCRESOL GREEN(BCG) - DYE BINDING				
GLOBULIN	3.4		2.0 - 3.5	g/dL
METHOD : CALCULATED PARAMETER				
ALBUMIN/GLOBULIN RATIO	1.3		1.0 - 2.1	RATIO
METHOD : CALCULATED PARAMETER				
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	26		< OR = 35	U/L
METHOD : SPECTROPHOTOMETRY, WITH PYRIDOXAL PHOSPHATE ACTIVATION-IFCC				
ALANINE AMINOTRANSFERASE (ALT/SGPT)	26		< OR = 35	U/L
METHOD : SPECTROPHOTOMETRY, WITH PYRIDOXAL PHOSPHATE ACTIVATION-IFCC				
ALKALINE PHOSPHATASE	**116**	**High**	35 - 104	U/L
METHOD : SPECTROPHOTOMETRY, PNPP, AMP BUFFER - IFCC				
GAMMA GLUTAMYL TRANSFERASE (GGT)	17		0 - 40	U/L
METHOD : ENZYMATIC COLORIMETRIC ASSAY STANDARDIZED AGAINST IFCC / SZASZ				
LACTATE DEHYDROGENASE	128		125 - 220	U/L
METHOD : SPECTROPHOTOMETRY, LACTATE TO PYRUVATE - UV-IFCC				
BLOOD UREA NITROGEN (BUN), SERUM				
BLOOD UREA NITROGEN	12.5		6 - 20	mg/dL
METHOD : SPECTROPHOTOMETRY, KINETIC TEST WITH UREASE AND GLUTAMATE DEHYDROGENASE				
CREATININE, SERUM				
CREATININE	0.70		0.5 - 0.9	mg/dL

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METHOD : SPECTROPHOTOMETRIC, JAFFE'S KINETICS				
BUN/CREAT RATIO				
BUN/CREAT RATIO	**18.00**	**High**	8.0 - 15.0	
METHOD : CALCULATED PARAMETER				
URIC ACID, SERUM				
URIC ACID	5.6		2.4 - 5.7	mg/dL
METHOD : SPECTROPHOTOMETRY, URICASE				
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN	7.9		6.0 - 8.0	g/dL
METHOD : SPECTROPHOTOMETRY, BIURET				
ALBUMIN, SERUM				
ALBUMIN	4.5		3.97 - 4.94	g/dL
METHOD : SPECTROPHOTOMETRY, BROMOCRESOL GREEN(BCG) - DYE BINDING				
GLOBULIN				
GLOBULIN	3.4		2.0 - 3.5	g/dL
METHOD : CALCULATED PARAMETER				
ELECTROLYTES (NA/K/CL), SERUM				
SODIUM, SERUM	138		136 - 145	mmol/L
METHOD : ISE INDIRECT				
POTASSIUM, SERUM	4.1		3.5 - 5.1	mmol/L
METHOD : ISE INDIRECT				
CHLORIDE, SERUM	101		98 - 107	mmol/L
METHOD : ISE INDIRECT				

Interpretation(s)

PHYSICAL EXAMINATION, URINE

COLOR	PALE YELLOW
APPEARANCE	**TURBID**

Comments

NOTE :MICROSCOPIC EXAMINATION OF URINE IS PERFORMED ON CENTRIFUGED URINARY SEDIMENT.
IN NORMAL URINE SAMPLES CAST AND CRYSTALS ARE NOT DETECTED.

CHEMICAL EXAMINATION, URINE

PH	6.5	4.7 - 7.5

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SPECIFIC GRAVITY	<=1.005	1.003 - 1.035	
PROTEIN	NOT DETECTED	NOT DETECTED	
GLUCOSE	NOT DETECTED	NOT DETECTED	
KETONES	NOT DETECTED	NOT DETECTED	
BLOOD	**DETECTED (TRACE)**	NOT DETECTED	
BILIRUBIN	NOT DETECTED	NOT DETECTED	
UROBILINOGEN	NORMAL	NORMAL	
NITRITE	NOT DETECTED	NOT DETECTED	
LEUKOCYTE ESTERASE	DETECTED(+++)	NOT DETECTED	
MICROSCOPIC EXAMINATION, URINE			
RED BLOOD CELLS	**1 - 2**	NOT DETECTED	/HPF
PUS CELL (WBC'S)	**20-30**	0-5	/HPF
EPITHELIAL CELLS	**8-10**	0-5	/HPF
CASTS	NOT DETECTED		
CRYSTALS	NOT DETECTED		
BACTERIA	**DETECTED (FEW)**	NOT DETECTED	

METHOD : DIP STICK/MICRO SCOPY/REFLECTANCE SPECTROPHOTOMETRY

Interpretation(s)

THYROID PANEL, SERUM			
T3	125.0	80 - 200	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNO ASSAY			
T4	9.60	5.1 - 14.1	µg/dL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNO ASSAY			
TSH (ULTRASENSITIVE)	2.860	0.27 - 4.2	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNO ASSAY			

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Interpretation(s)

Triiodothyronine T3 , **Thyroxine T4,** and **Thyroid Stimulating Hormone TSH** are thyroid hormones which affect almost every physiological process in the body, including growth, development, metabolism, body temperature, and heart rate.
Production of T3 and its prohormone thyroxine (T4) is activated by thyroid-stimulating hormone (TSH), which is released from the pituitary gland. Elevated concentrations of T3, and T4 in the blood inhibit the production of TSH.
Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called hypothyroidism.
In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hyperthyroidism, TSH levels are low.
owidctlparowidctlparBelow mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3.Measurement of the serum TT3 level is a more sensitive test for the diagnosis of hyperthyroidism, and measurement of TT4 is more useful in the diagnosis of hypothyroidism.Most of the thyroid hormone in blood is bound to transport proteins. Only a very small fraction of the circulating hormone is free and biologically active. It is advisable to detect Free T3, FreeT4 along with TSH, instead of testing for albumin bound Total T3, Total T4.

Sr. No.	TSH	Total T4	FT4	Total T3	Possible Conditions
1	High	Low	Low	Low	(1) Primary Hypothyroidism (2) Chronic autoimmune Thyroiditis (3) Post Thyroidectomy (4) Post Radio-Iodine treatment
2	High	Normal	Normal	Normal	(1)Subclinical Hypothyroidism (2) Patient with insufficient thyroid hormone replacement therapy (3) In cases of Autoimmune/Hashimoto thyroiditis (4). Isolated increase in TSH levels can be due to Subclinical inflammation, drugs like amphetamines, Iodine containing drug and dopamine antagonist e.g. domperidone and other physiological reasons.
3	Normal/Low	Low	Low	Low	(1) Secondary and Tertiary Hypothyroidism
4	Low	High	High	High	(1) Primary Hyperthyroidism (Graves Disease) (2) Multinodular Goitre (3)Toxic Nodular Goitre (4) Thyroiditis (5) Over treatment of thyroid hormone (6) Drug effect e.g. Glucocorticoids, dopamine, T4 replacement therapy (7) First trimester of Pregnancy
5	Low	Normal	Normal	Normal	(1) Subclinical Hyperthyroidism
6	High	High	High	High	(1) TSH secreting pituitary adenoma (2) TRH secreting tumor
7	Low	Low	Low	Low	(1) Central Hypothyroidism (2) Euthyroid sick syndrome (3) Recent treatment for Hyperthyroidism
8	Normal/Low	Normal	Normal	High	(1) T3 thyrotoxicosis (2) Non-Thyroidal illness
9	Low	High	High	Normal	(1) T4 Ingestion (2) Thyroiditis (3) Interfering Anti TPO antibodies

REF: 1. TIETZ Fundamentals of Clinical chemistry 2.Guidlines of the American Thyroid association duriing pregnancy and Postpartum, 2011.
NOTE: It is advisable to detect Free T3,FreeT4 along with TSH, instead of testing for albumin bound Total T3, Total T4.TSH is not affected by variation in thyroid - binding protein. TSH has a diurnal rhythm, with peaks at 2:00 - 4:00 a.m. And troughs at 5:00 - 6:00 p.m. With ultradian variations.

STOOL: OVA & PARASITE

REMARK SUSCEPTIBILITY TEST CANCELLED AS CULTURE WAS NEGATIVE

METHOD : MICROSCOPIC EXAMINATION

Interpretation(s)

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ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP	O	
METHOD : HEMAGGLUTINATION REACTION ON SOLID PHASE		
RH TYPE	RH+	
METHOD : HEMAGGLUTINATION REACTION ON SOLID PHASE		

XRAY-CHEST

»»	BOTH THE LUNG FIELDS ARE CLEAR	
»»	BOTH THE COSTOPHRENIC AND CARDIOPHRENIC ANGLES ARE CLEAR	
»»	BOTH THE HILA ARE NORMAL	
»»	CARDIAC AND AORTIC SHADOWS APPEAR NORMAL	
»»	BOTH THE DOMES OF THE DIAPHRAGM ARE NORMAL	
»»	VISUALIZED BONY THORAX IS NORMAL	
IMPRESSION	NO ABNORMALITY DETECTED	

TMT OR ECHO

TMT OR ECHO — ECHO REPORT

- Normal sized cardiac chambers and normal valves
- Trivial MR, Trivial TR
- No RWMA
- Normal LV systolic function LVEF ~ 60 %
- Grade I LV diastolic dysfunction, E<A
- No Clot/Vegetation/Pericardial Effusion
- IVS/IAS intact,no flow seen across.

ECG

ECG — NSR , T INVERSION IN V1-V4

MEDICAL HISTORY

RELEVANT PRESENT HISTORY	HYPERTENSION - 10 YEARS
RELEVANT PAST HISTORY	NOT SIGNIFICANT
RELEVANT PERSONAL HISTORY	MARRIED TWO CHILDREN PERI MENOPAUSAL
LMP (FOR FEMALES)	2 MONTHS AGO
RELEVANT FAMILY HISTORY	HIGH BP - PARENTS DIABETES - MOTHER
OCCUPATIONAL HISTORY	HOMEMAKER
HISTORY OF MEDICATIONS	UNDER TREATMENT

ANTHROPOMETRIC DATA & BMI

HEIGHT IN METERS	1.62	mts

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WEIGHT IN KGS.	80		Kgs
BMI	30	BMI & Weight Status as follows: Below 18.5: Underweight 18.5 - 24.9: Normal 25.0 - 29.9: Overweight 30.0 and Above: Obese	kg/sqmts
GENERAL EXAMINATION			
MENTAL / EMOTIONAL STATE	NORMAL		
PHYSICAL ATTITUDE	NORMAL		
GENERAL APPEARANCE / NUTRITIONAL STATUS	OBESE		
BUILT / SKELETAL FRAMEWORK	AVERAGE		
FACIAL APPEARANCE	NORMAL		
SKIN	NORMAL		
UPPER LIMB	NORMAL		
LOWER LIMB	NORMAL		
NECK	NORMAL		
NECK LYMPHATICS / SALIVARY GLANDS	NOT ENLARGED OR TENDER		
THYROID GLAND	NOT ENLARGED		
CAROTID PULSATION	NORMAL		
TEMPERATURE	NORMAL		
PULSE	82 / MIN REGULAR, ALL PERIPHERAL PULSES WELL FELT, NO CAROTID BRUIT		
RESPIRATORY RATE	NORMAL		
CARDIOVASCULAR SYSTEM			
BP	150/96 MMHG (SUPINE)		mm/Hg
PERICARDIUM	NORMAL		
APEX BEAT	NORMAL		
HEART SOUNDS	S1, S2 HEARD NORMALLY		
MURMURS	ABSENT		
RESPIRATORY SYSTEM			
SIZE AND SHAPE OF CHEST	NORMAL		
MOVEMENTS OF CHEST	SYMMETRICAL		
BREATH SOUNDS INTENSITY	NORMAL		
BREATH SOUNDS QUALITY	VESICULAR (NORMAL)		

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DIAGNOSTIC REPORT

Patient Ref. No. 775000001933147

SRL Diagnostics

CLIENT CODE : C000138354

CLIENT'S NAME AND ADDRESS :
ACROFEMI HEALTHCARE LTD (MEDIWHEEL)
F-703, LADO SARAI, MEHRAULI
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NEW DELHI 110030
DELHI INDIA
8800465156

SRL Ltd
Shop CG 017, PALM SPRINGS PLAZA
GURUGRAM, 122001
HARYANA, INDIA
Tel : 9111591115

PATIENT NAME : GEETANJALI SETHI PATIENT ID : **GEETF210670282**

ACCESSION NO : **0282VK002109** AGE : 52 Years SEX : Female ABHA NO :

DRAWN : RECEIVED : 28/11/2022 08:41:16 REPORTED : 29/11/2022 12:31:04

REFERRING DOCTOR : SELF CLIENT PATIENT ID :

Test Report Status **Final**	Results	Biological Reference Interval	Units
ADDED SOUNDS	ABSENT		
PER ABDOMEN			
APPEARANCE	NORMAL		
VENOUS PROMINENCE	ABSENT		
LIVER	NOT PALPABLE		
SPLEEN	NOT PALPABLE		
CENTRAL NERVOUS SYSTEM			
HIGHER FUNCTIONS	NORMAL		
CRANIAL NERVES	NORMAL		
CEREBELLAR FUNCTIONS	NORMAL		
SENSORY SYSTEM	NORMAL		
MOTOR SYSTEM	NORMAL		
REFLEXES	NORMAL		
MUSCULOSKELETAL SYSTEM			
SPINE	NORMAL		
JOINTS	NORMAL		
BASIC EYE EXAMINATION			
DISTANT VISION RIGHT EYE WITH GLASSES	6/6		
DISTANT VISION LEFT EYE WITH GLASSES	6/6		
NEAR VISION RIGHT EYE WITH GLASSES	N/6		
NEAR VISION LEFT EYE WITH GLASSES	N/6		
COLOUR VISION	17/17		
SUMMARY			
REMARKS / RECOMMENDATIONS	ADVISED LIFESTYLE CHANGES REGULAR BP & BLOOD SUGAR RECORD REPEAT URINE RE AFTER PLENTY OF ORAL FLUIDS, FOLLOW UP WITH PHYSICIAN & EYE SPECIALIST. CONSULT GYAECOLOGIST IN VIEW OF USG FINDINGS. REVIEW WITH ECG,CXR REPORTS.		

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MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE

ULTRASOUND ABDOMEN

ULTRASOUND ABDOMEN

GRADE I FATTY CHANGES IN LIVER
UTERINE FIBROID

Interpretation(s)
BLOOD COUNTS,EDTA WHOLE BLOOD-The cell morphology is well preserved for 24hrs. However after 24-48 hrs a progressive increase in MCV and HCT is observed leading to a decrease in MCHC. A direct smear is recommended for an accurate differential count and for examination of RBC morphology.
RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(>13) from Beta thalassaemia trait
(<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.
WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.
(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504
This ratio element is a calculated parameter and out of NABL scope.
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD-**TEST DESCRIPTION** :-
Erythrocyte sedimentation rate (ESR) is a test that indirectly measures the degree of inflammation present in the body. The test actually measures the rate of fall (sedimentation) of erythrocytes in a sample of blood that has been placed into a tall, thin, vertical tube. Results are reported as the millimetres of clear fluid (plasma) that are present at the top portion of the tube after one hour. Nowadays fully automated instruments are available to measure ESR.

ESR is not diagnostic; it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an inflammatory condition.CRP is superior to ESR because it is more sensitive and reflects a more rapid change.
TEST INTERPRETATION
Increase in: Infections, Vasculities, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.
Finding a very accelerated ESR**(>100 mm/hour)** in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).
In pregnancy BRI in first trimester is 0-48 mm/hr(62 if anemic) and in second trimester (0-70 mm /hr(95 if anemic). ESR returns to normal 4th week post partum.
Decreased in: Polycythermia vera, Sickle cell anemia

LIMITATIONS
False elevated ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia
False Decreased : Poikilocytosis,(SickleCells,spherocytes),Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine, salicylates)

REFERENCE :
1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition;2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin;3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis,10th edition.
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD-**Used For**:

1.Evaluating the long-term control of blood glucose concentrations in diabetic patients.
2.Diagnosing diabetes.
3.Identifying patients at increased risk for diabetes (prediabetes).
The ADA recommends measurement of HbA1c (typically 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to determine whether a patients metabolic control has remained continuously within the target range.
1.eAG (Estimated average glucose) converts percentage HbA1c to md/dl, to compare blood glucose levels.
2. eAG gives an evaluation of blood glucose levels for the last couple of months.
3. eAG is calculated as eAG (mg/dl) = 28.7 * HbA1c - 46.7

HbA1c Estimation can get affected due to :
I.Shortened Erythrocyte survival : Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g. recovery from acute blood loss,hemolytic anemia) will falsely lower HbA1c test results.Fructosamine is recommended in these patients which indicates diabetes control over 15 days.
II.Vitamin C & E are reported to falsely lower test results.(possibly by inhibiting glycation of hemoglobin.

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III.Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia,uremia, hyperbilirubinemia, chronic alcoholism,chronic ingestion of salicylates & opiates addiction are reported to interfere with some assay methods,falsely increasing results.
IV.Interference of hemoglobinopathies in HbA1c estimation is seen in
a.Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
b.Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
c.HbF > 25% on alternate paltform (Boronate affinity chromatography) is recommended for testing of HbA1c.Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy
GLUCOSE FASTING,FLUORIDE PLASMA-**TEST DESCRIPTION**
Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and sothat no glucose is excreted in the urine.
Increased in
Diabetes mellitus, Cushing' s syndrome (10 – 15%), chronic pancreatitis (30%). Drugs:corticosteroids,phenytoin, estrogen, thiazides.
Decreased in
Pancreatic islet cell disease with increased insulin,insulinoma,adrenocortical insufficiency, hypopituitarism,diffuse liver disease, malignancy (adrenocortical, stomach,fibrosarcoma), infant of a diabetic mother, enzyme deficiency diseases(e.g., galactosemia),Drugs- insulin, ethanol, propranolol; sulfonylureas,tolbutamide, and other oral hypoglycemic agents.
NOTE:
Hypoglycemia is defined as a glucoseof < 50 mg/dL in men and< 40 mg/dL in women.
While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values), there is wide fluctuation within individuals.Thus, glycosylated hemoglobin(HbA1c) levels are favored to monitor glycemic control.
High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glyosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.
GLUCOSE, POST-PRANDIAL, PLASMA-High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glyosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.Additional test HbA1c
LIVER FUNCTION PROFILE, SERUM-
LIVER FUNCTION PROFILE
Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice.Elevated levels results from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors &Scarring of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of Hemolytic or pernicious anemia, Transfusion reaction & a common metabolic condition termed Gilbert syndrome, due to low levels of the enzyme that attaches sugar molecules to bilirubin.
AST is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of the liver,liver cancer,kidney failure,hemolytic anemia,pancreatitis,hemochromatosis. AST levels may also increase after a heart attack or strenuous activity.ALT test measures the amount of this enzyme in the blood.ALT is found mainly in the liver, but also in smaller amounts in the kidneys,heart,muscles, and pancreas.It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health.AST levels increase during acute hepatitis,sometimes due to a viral infection,ischemia to the liver,chronic hepatitis,obstruction of bile ducts,cirrhosis.
ALP is a protein found in almost all body tissues.Tissues with higher amounts of ALP include the liver,bile ducts and bone.Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Paget's disease,Rickets,Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia,Malnutrition,Protein deficiency,Wilson's disease.GGT is an enzyme found in cell membranes of many tissues mainly in the liver,kidney and pancreas.It is also found in other tissues including intestine,spleen,heart, brain and seminal vesicles.The highest concentration is in the kidney,but the liver is considered the source of normal enzyme activity.Serum GGT has been widely used as an index of liver dysfunction.Elevated serum GGT activity can be found in diseases of the liver,biliary system and pancreas.Conditions that increase serum GGT are obstructive liver disease,high alcohol consumption and use of enzyme-inducing drugs etc.Serum total protein,also known as total protein,is a biochemical test for measuring the total amount of protein in serum.Protein in the plasma is made up of albumin and globulin.Higher-than-normal levels may be due to:Chronic inflammation or infection,including HIV and hepatitis B or C,Multiple myeloma,Waldenstrom's disease.Lower-than-normal levels may be due to: Agammaglobulinemia,Bleeding (hemorrhage),Burns,Glomerulonephritis,Liver disease, Malabsorption,Malnutrition,Nephrotic syndrome,Protein-losing enteropathy etc.Human serum albumin is the most abundant protein in human blood plasma.It is produced in the liver.Albumin constitutes about half of the blood serum protein.Low blood albumin levels (hypoalbuminemia) can be caused by:Liver disease like cirrhosis of the liver, nephrotic syndrome,protein-losing enteropathy,Burns,hemodilution,increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc
BLOOD UREA NITROGEN (BUN), SERUM-Causes of Increased levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)
Causes of decreased level include Liver disease, SIADH.
CREATININE, SERUM-Higher than normal level may be due to:
• Blockage in the urinary tract
• Kidney problems, such as kidney damage or failure, infection, or reduced blood flow
• Loss of body fluid (dehydration)
• Muscle problems, such as breakdown of muscle fibers
• Problems during pregnancy, such as seizures (eclampsia)), or high blood pressure caused by pregnancy (preeclampsia)

Lower than normal level may be due to:
• Myasthenia Gravis
• Muscular dystrophy

DIAGNOSTIC REPORT

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URIC ACID, SERUM-
Causes of Increased levels:-Dietary(High Protein Intake,Prolonged Fasting,Rapid weight loss),Gout,Lesch nyhan syndrome,Type 2 DM,Metabolic syndrome
Causes of decreased levels-Low Zinc intake,OCP,Multiple Sclerosis
TOTAL PROTEIN, SERUM-
Serum total protein,also known as total protein, is a biochemical test for measuring the total amount of protein in serum..Protein in the plasma is made up of albumin and globulin

Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenstrom's disease
Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage),Burns,Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome,Protein-losing enteropathy etc.
ALBUMIN, SERUM-
Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc.
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-
Blood group is identified by antigens and antibodies present in the blood. Antigens are protein molecules found on the surface of red blood cells. Antibodies are found in plasma. To determine blood group, red cells are mixed with different antibody solutions to give A,B,O or AB.

Disclaimer: "Please note, as the results of previous ABO and Rh group (Blood Group) for pregnant women are not available, please check with the patient records for availability of the same."

The test is performed by both forward as well as reverse grouping methods.
MEDICAL
HISTORY-**********
THIS REPORT CARRIES THE SIGNATURE OF OUR LABORATORY DIRECTOR. THIS IS AN INVIOLABLE FEATURE OF OUR LAB MANAGEMENT SOFTWARE. HOWEVER, ALL EXAMINATIONS AND INVESTIGATIONS HAVE BEEN CONDUCTED BY OUR PANEL OF DOCTORS.

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****End Of Report****
Please visit www.srlworld.com for related Test Information for this accession

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CONDITIONS OF LABORATORY TESTING & REPORTING

1. It is presumed that the test sample belongs to the patient named or identified in the test requisition form.
2. All tests are performed and reported as per the turnaround time stated in the SRL Directory of Services.
3. Result delays could occur due to unforeseen circumstances such as non-availability of kits / equipment breakdown / natural calamities / technical downtime or any other unforeseen event.
4. A requested test might not be performed if:
   i. Specimen received is insufficient or inappropriate
   ii. Specimen quality is unsatisfactory
   iii. Incorrect specimen type
   iv. Discrepancy between identification on specimen container label and test requisition form
5. SRL confirms that all tests have been performed or assayed with highest quality standards, clinical safety & technical integrity.
6. Laboratory results should not be interpreted in isolation; it must be correlated with clinical information and be interpreted by registered medical practitioners only to determine final diagnosis.
7. Test results may vary based on time of collection, physiological condition of the patient, current medication or nutritional and dietary changes. Please consult your doctor or call us for any clarification.
8. Test results cannot be used for Medico legal purposes.
9. In case of queries please call customer care (91115 91115) within 48 hours of the report.

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SRL Limited
Fortis Hospital, Sector 62, Phase VIII,
Mohali 160062

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